

## APPENDIX A

A.1. Baseline Questionnaire .....	
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## **A.1. Baseline Questionnaire**

# **An Ergonomic-Epidemiologic Study of the Low Back: Baseline Questionnaire**

Directions:

Please answer each question by pointing the arrow with the mouse and clicking with you index finger to either mark “yes” or “no” or to fill in a blank. If you need help or have any questions please ask one of our research assistants. We’re happy to help!

Code # \_\_\_\_\_  
Date: \_\_\_\_\_

## **An Ergonomic-Epidemiologic Study of the Low Back: Baseline Questionnaire**

1. Your Company's name: \_\_\_\_\_
2. Department: \_\_\_\_\_
3. Job Title: \_\_\_\_\_
4. Age (in tenths) \_\_\_\_\_.\_\_ years (calculated on the computer)
5. Gender: \_\_\_\_ Male \_\_\_\_ Female
6. How long have you worked for <<company name>>? \_\_\_\_ years \_\_\_\_ months
7. How long have you worked at your current job? \_\_\_\_ years \_\_\_\_ months
8. Altogether, approximately how many miles do you travel in a car or bus on an average day?  
\_\_\_\_ miles
9. Altogether, approximately how many minutes do you spend traveling one way to your job on  
an average day? \_\_\_\_ Hours \_\_\_\_ Minutes
10. Do you walk on a regular basis **at least twice a month** outside of work? \_\_\_\_ Yes \_\_\_\_ No
  - a. If yes,

Type of Exercise	Number of months per year	Average number of times per week	Average number of minutes each time
Walking	Months	Per week	Minutes

- b. Do you do any other exercise outside of work (for example, bicycling, basketball, skiing, or swimming) at least twice a month? \_\_\_\_ Yes \_\_\_\_ No

*If no, skip to question 11.*

- a. Which of the following types of exercise (outside of work) do you do?

Type of Exercise	Yes	No	Number of months per year	Average number of times per week	Average number of minutes each time
Aerobics, Jazzercise			Months	Per week	Minutes
Running, Jogging			Months	Per week	Minutes
Bowling			Months	Per week	Minutes
Bicycling			Months	Per week	Minutes
Swimming			Months	Per week	Minutes
Weight Lifting			Months	Per week	Minutes
Baseball			Months	Per week	Minutes
Basketball			Months	Per week	Minutes
Football			Months	Per week	Minutes
Soccer			Months	Per week	Minutes
Racquetball			Months	Per week	Minutes
Handball			Months	Per week	Minutes
Tennis			Months	Per week	Minutes
Snow Skiing or Snowboarding			Months	Per week	Minutes
Water Skiing or Wave Runner			Months	Per week	Minutes
Hunting			Months	Per week	Minutes
Fishing			Months	Per week	Minutes
Martial Arts (Karate, Judo, etc.)			Months	Per week	Minutes
Other (please list)			Months	Per week	Minutes
Other (please list)			Months	Per week	Minutes

11. Altogether, outside of work, approximately how much time in a usual day do you spend sitting down (e.g. watching TV, reading, using a computer, and/or going to the movies, etc...)? \_\_\_\_\_ hours \_\_\_\_\_ min. per day
12. Outside of work do you participate in any activities or hobbies (for example, gardening, snow shoveling, car maintenance or doing housework, etc.) on a regular basis, at least twice a month?

*If no, skip to question 13.*

Type of Hobby	Yes	No	Number of months per year	Average number of times per week	Average number of minutes each time
Yoga / martial arts / relaxation therapy			Months	Per week	Minutes
Gardening, Landscaping			Months	Per week	Minutes
Snow Shoveling			Months	Per week	Minutes
Maintenance (e.g. car or engine repair), Mechanical Work			Months	Per week	Minutes
Driving a motorcycle or ATV			Months	Per week	Minutes
Snowmobiling			Months	Per week	Minutes
Building and/or repairing furniture or woodworking			Months	Per week	Minutes
Remodeling or building a home			Months	Per week	Minutes
Housework (mopping, cleaning, dusting, etc)			Months	Per week	Minutes
Knit, sewing, needlepoint, crocheting. Or arts and crafts			Months	Per week	Minutes
Other (please specify)			Months	Per week	Minutes
Other (please specify)			Months	Per week	Minutes

13. Have you ever been told by a physician that you have any of the following:

- a. Diabetes: \_\_\_\_\_ Yes \_\_\_\_\_ No  
Approximately how many years ago was this diagnosed? \_\_\_\_\_ Years

With which of the following are you treating the Diabetes?

- \_\_\_\_\_ Insulin  
\_\_\_\_\_ Pills / Oral Agents  
\_\_\_\_\_ Both Insulin and Pills  
\_\_\_\_\_ Diet only (no insulin or pills)

b. Chronic Fatigue Syndrome? ☐ Yes ☐ No

c. Irritable Bowel Syndrome? ☐ Yes ☐ No

d. Thyroid problem: ☐ Yes ☐ No

e. Gout: ☐ Yes ☐ No

f. Kidney Failure: ☐ Yes ☐ No

g. High Blood Pressure: ☐ Yes ☐ No

h. High cholesterol (Laboratory test result over 200 mg/dL) ☐ Yes ☐ No

i. Hernia (Abdominal or Inguinal hernia, **does not** include herniation of disk in neck or back):

☐ Abdominal (Belly Button)

☐ Inguinal (Groin)

☐ Both

14. Have you ever been diagnosed with any other problems?

a. Other: \_\_\_\_\_ (please specify) ☐ Yes ☐ No

b. Other: \_\_\_\_\_ (please specify) ☐ Yes ☐ No

c. Other: \_\_\_\_\_ (please specify) ☐ Yes ☐ No

d. Other: \_\_\_\_\_ (please specify) ☐ Yes ☐ No

e. Other : \_\_\_\_\_ (please specify) ☐ Yes ☐ No

f. Other: \_\_\_\_\_ (please specify) ☐ Yes ☐ No

15. How often do you have back pain and/or back stiffness when getting out of bed in the morning?

☐ Never

☐ Seldom

☐ Often

☐ Always

16. How often do you get back pain and/or back stiffness when driving or riding in a car within 1 hour?

☐ Never

- ☐ Seldom
- ☐ Often
- ☐ Always

17. What is the most you weighed in your life, excluding pregnancy? \_\_\_\_\_ lbs.

18. What was your weight when you were 20 years old? \_\_\_\_\_ lbs.

19. Marital Status:

- ☐ Never married (Single)
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed/Widowed

20. What is the highest grade in school that you completed?

- ☐ 8<sup>th</sup> grade or less
- ☐ Some high school
- ☐ High school graduate or GED
- ☐ Some college
- ☐ College graduate (Bachelor's Degree or higher)

21. Have you ever smoked tobacco?

- ☐ Never
  - ☐ Yes, current
  - ☐ Yes, but smoked in the past
- If never, go to question 22...otherwise*

How old were you when you started smoking? \_\_\_\_\_ years old

How old were you when you quit smoking? \_\_\_\_\_ years old

On average, how many cigarettes did you smoke per day? \_\_\_\_\_ Cigarettes per day

22. In the past, have you ever had a problem with alcohol? ☐ Yes ☐ No

a. If yes, approximately how many years ago? \_\_\_\_\_ Years

23. What is your race/ethnicity is (if you wish to select more than one please either contact a research assistant or select "Other and type in your choices):

- ☐ Caucasian or White
- ☐ Hispanic or Latino
- ☐ African American or Black
- ☐ Asian
- ☐ Pacific Islander or Native Hawaiian
- ☐ Native American or Alaskan Native
- ☐ Other (please specify) \_\_\_\_\_
- ☐ Decline to answer this question.

24. For women only:

Are you currently:

a. Pregnant? \_\_\_\_ Yes \_\_\_\_ No

i. If yes, when is your due date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

b. How many times have you been pregnant? \_\_\_\_

c. How many children have you given birth to? \_\_\_\_

25. How many brothers do you have (biological)? \_\_\_\_

26. How many sisters do you have (biological)? \_\_\_\_

27. Has any one in your family (blood relatives only) ever had a pinched nerve, Sciatica, or Lumbar Radiculopathy in the lower back? \_\_\_\_ Yes \_\_\_\_ No

a. If yes, write in how many of each

Biological Sister(s)		Biological Brother(s)	
Biological Mother		Biological Father	

28. Has any one in your family (blood relatives only) ever been diagnosed Cervical Radiculopathy or a pinched nerve in the neck? \_\_\_\_ Yes \_\_\_\_ No

a. If yes, write in how many of each

Biological Sister(s)		Biological Brother(s)	
Biological Mother		Biological Father	

29. How often do you have family problems that irritate or bother you?

\_\_\_\_ Never  
\_\_\_\_ Sometimes  
\_\_\_\_ Often  
\_\_\_\_ Always

30. How often during the past month have you felt uneasy?



- ☐ Never
- ☐ Sometimes
- ☐ Often
- ☐ Always

31. How well do you sleep at night?

- ☐ Very well
- ☐ Well
- ☐ Fair
- ☐ Poorly
- ☐ Very poorly

32. How often during the past month have you felt “on the edge”?

- ☐ Never
- ☐ Sometimes
- ☐ Often
- ☐ Always

33. How often during the past month have you felt tense?

- ☐ Never
- ☐ Sometimes
- ☐ Often
- ☐ Always

34. How often during the past month has your sleep been restless?

- ☐ Never
- ☐ Sometimes
- ☐ Often
- ☐ Always

35. How often are you physically exhausted after work?

- ☐ Never
- ☐ Sometimes
- ☐ Often
- ☐ Always

36. How often are you mentally exhausted after work?

- ☐ Never
- ☐ Sometimes
- ☐ Often
- ☐ Always

37. How often during the past month have you felt “down”, blue or depressed?

- ☐ Never
- ☐ Sometimes

- ☐ Often
- ☐ Always

38. How often during the past month have you felt nervous or anxious?

- ☐ Never
- ☐ Sometimes
- ☐ Often
- ☐ Always

*The next group of questions pertain to feelings you have concerning your job.*

39. All in all, how satisfied are you with your job?

- ☐ Very satisfied
- ☐ Somewhat Satisfied
- ☐ A little satisfied
- ☐ Not at all satisfied

40. My job requires working very fast.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

41. My job requires working very hard (physically).

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

42. I am NOT asked to do an excessive amount of work.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

43. I have enough time to get the job done.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

44. I am free from conflicting demands that others make.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

45. How much influence or control do you have over the variety of tasks you perform?

- ☐ Very Much
- ☐ Much
- ☐ Moderate Amount
- ☐ A Little
- ☐ Very Little

46. How much influence or control do you have over the order in which you perform tasks at work?

- ☐ Very Much
- ☐ Much
- ☐ Moderate Amount
- ☐ A Little
- ☐ Very Little

47. How much influence or control do you have over the pace of your work, that is how fast or slow do you work?

- ☐ Very Much
- ☐ Much
- ☐ Moderate Amount
- ☐ A Little
- ☐ Very Little

48. How much influence or control do you have over the extent to which you can work ahead and take a short break during work hours?

- ☐ Very Much
- ☐ Much
- ☐ Moderate Amount
- ☐ A Little
- ☐ Very Little

49. How firm or hard is the mattress you sleep on?

- ☐ Hard
- ☐ Medium
- ☐ Soft

50. On average, about how many total hours of sleep do you get per night (don't count time you are laying awake or trying to fall asleep)?

I average \_\_\_\_\_ total hours of sleep per night

51. Please look at the sleep positions below. Choose and rank up to two that are closest to the positions you think you use at night. If A, B, or C is selected, please indicate which side you sleep on.

\_\_\_\_\_ 1<sup>st</sup> most common \_\_\_\_\_ right side \_\_\_\_\_ left side \_\_\_\_\_ both equally  
 \_\_\_\_\_ 2<sup>nd</sup> most common \_\_\_\_\_ right side \_\_\_\_\_ left side \_\_\_\_\_ both equally



A



B



C



D



E



F

### Modified Work APGAR

Please place a checkmark in the box corresponding with how you feel about each of the following statements.

		Almost always	Some of the time	Hardly ever
52.	I am satisfied that I can turn to a fellow worker for help if something is troubling me.			
53.	I am satisfied with the way my fellow workers talk things over with me and share problems with me.			
54.	I am satisfied that my fellow workers accept and support my new ideas and thoughts.			
55.	I am satisfied with the way my fellow workers respond to my emotions, such as anger, sorrow, or laughter.			
56.	I am satisfied with the way my fellow workers and I share time together.			
57.	I enjoy the tasks involved in my job.			

58.	I am satisfied with how well I get along with my closest or immediate supervisor.			
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### Modified Zung Depression Index

Please indicate for each of the following questions which answer best describes how you have been feeling recently.				
	Rarely or none of the time (less than 1 day per week)	Some or little of the time (1–2 days per week)	A moderate amount of time (3–4 times per week)	Most of the time (5–7 days per week)
59. I feel downhearted and sad				
60. I feel that nobody cares				
61. I get tired for no reason				
62. I feel that I am useful and needed				
63. I am still able to enjoy those things I used to				
64. I eat as much as I used to				
65. I am more irritable than usual				
66. I feel hopeful about the future				

*Thank you for completing the questionnaire.*

## A.2 Structured Interview

Plant: \_\_\_\_\_  
 Subject ID # \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Time: \_\_\_\_\_  
 Examiner 1: \_\_\_\_\_  
 Examiner 2: \_\_\_\_\_

**Back Baseline Structured Interview (to be completed on a laptop computer)**

59. Have you ever been told by a health care professional (medical doctor/chiropractor) that you have any of the following:

- a. Rheumatoid arthritis, Lupus, or another inflammatory arthritis (not typical Osteoarthritis or Degenerative Arthritis). \_\_\_\_ Yes \_\_\_\_ No  
 Approximately how many years ago was this diagnosed? \_\_\_\_\_ Years
- b. Osteoarthritis or Degenerative Arthritis \_\_\_\_ Yes \_\_\_\_ No
- i. If yes, what joints have been affected? (check all that apply)

<input checked="" type="checkbox"/>	Body Part	Which side is affected?			Approximately how many years ago was this diagnosed?
		Right	Left	Both	
<input type="checkbox"/>	Fingers				Years
<input type="checkbox"/>	Wrists				Years
<input type="checkbox"/>	Elbows				Years
<input type="checkbox"/>	Shoulders				Years
<input type="checkbox"/>	Neck				Years
<input type="checkbox"/>	Upper Back				Years
<input type="checkbox"/>	Middle Back				Years
<input type="checkbox"/>	Low Back				Years
<input type="checkbox"/>	Hips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Years
<input type="checkbox"/>	Knees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Years
<input type="checkbox"/>	Ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Years
<input type="checkbox"/>	Toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Years

c. Fibromyalgia? ☐ Yes ☐ No

d. Myofascial Pain Syndrome? ☐ Yes ☐ No

e. Infection in the back bone (Osteomyelitis). ☐ Yes ☐ No  
What bone(s) were infected: \_\_\_\_\_ (please specify)

f. Osteoporosis: \_\_\_\_\_ (please specify) ☐ Yes ☐ No  
Please specify what bones were osteoporotic \_\_\_\_\_

g. Have you ever had a broken bone or fracture? ☐ Yes ☐ No

If yes, which bone(s) did you fracture?

Body Part	Check if yes	Right	Left	Bilateral
Foot / Ankle				
Calf / Tibia / Fibula (Lower Leg)				
Thigh / Femur				
Coccyx (Tail Bone)				
Pelvis				
Low Back / Lumbar Spine				
Middle Back / Thoracic Spine				
Neck / Cervical Spine				
Head / Skull				
Sternum (Breast Bone)				
Rib (s)				
Collar Bone / Clavicle				
Upper Arm / Humerus				
Lower Arm / Radius / Ulna				
Wrist				
Finger(s)				

60. Have you **EVER** had an accident or sudden injury to your Neck, Middle, or Lower Back (such as a motor vehicle accident, whiplash, sports injury, fracture, slip, trip, or fall)?  
☐ Yes ☐ No

a. If yes, please give year(s) of each:

Body Part	Approx. Year(s)	Did it occur at work?	Cause (check all that apply)		
Neck		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> MVA <input type="checkbox"/> Unsure	<input type="checkbox"/> Sports <input type="checkbox"/> Other	<input type="checkbox"/> Slip, Trip, Fall
Middle Back		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> MVA <input type="checkbox"/> Unsure	<input type="checkbox"/> Sports <input type="checkbox"/> Other	<input type="checkbox"/> Slip, Trip, Fall
Lower Back		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> MVA <input type="checkbox"/> Unsure	<input type="checkbox"/> Sports <input type="checkbox"/> Other	<input type="checkbox"/> Slip, Trip, Fall

61. Have you ever had surgery on your neck, back, legs, or feet? \_\_\_\_ Yes \_\_\_\_ No  
a. If yes, in what body part did you have surgery on?

Type of Surgery	Surgery		Describe
	Yes	No	
Neck			<input type="checkbox"/> Disk Removal <input type="checkbox"/> Vertebral Fusion <input type="checkbox"/> Other (specify)
Middle Back			<input type="checkbox"/> Disk Removal <input type="checkbox"/> Vertebral Fusion <input type="checkbox"/> Other (specify)
Low Back			<input type="checkbox"/> Disk Removal <input type="checkbox"/> Vertebral Fusion <input type="checkbox"/> Laminectomy <input type="checkbox"/> Other (specify)
Hip			<input type="checkbox"/> Hip Replacement <input type="checkbox"/> Other (specify)
Knee			<input type="checkbox"/> Cartilage Removed <input type="checkbox"/> Ligament Repair <input type="checkbox"/> Knee Replacement <input type="checkbox"/> Other (specify)
Foot			<input type="checkbox"/> Bunions / Corns / Calluses <input type="checkbox"/> Other (specify)

62. Have you **ever** been told by a health care professional (physician, chiropractor, etc.) that you have any of the following:

Disorder	Yes	No		Right	Left	Unsure
Neck Strain, Neck Sprain						
Pinched Nerve in the Neck (Cervical Radiculopathy)						
Bulging Disk in the Neck						
Degenerative Spine/Disk disease in the neck (Cervical)						
Lower Back Pain, Lower Back Strain, Lower Back Sprain						
Pinched nerve in the lower back (Sciatica)						
Sacroiliac Joint Dysfunction, Sacroiliitis						
Bulging Disk in the Lower Back						
Degenerative Spine/Disk disease in the low back (Lumbar)						
Spondylolisthesis						
Spina bifida						



Scoliosis						
Problem with Lower Spine / Vertebral Bone Alignment						
Other						
Other						
Other						

**The following questions ask about your history of LOW BACK PAIN in your life.**

63. Have you EVER had pain in your **Low Back Pain** that lasted at least 7 days?

\_\_\_\_\_ Yes \_\_\_\_\_ No

If answer to question 5 is yes, skip to question 6.

a. Have you EVER had pain in your **Low Back Pain** that lasted at least 3 days?

\_\_\_\_\_ Yes \_\_\_\_\_ No

If answer to question 5a is no, skip to question 11.

64. About how old were you when you first experienced **Low Back Pain** that lasted at least (3 or 7 depending on question 5) days?

\_\_\_\_\_ years old

65. How many episodes of **Low Back Pain** have you ever had lasting at least (3 or 7) days?

\_\_\_\_\_ episodes

a. Approximately how many of those episodes (answer from #7) lasting at least (3 or 7) days do you estimate were work-related? \_\_\_\_\_ episodes

b. How long ago was your **most recent** episode of **Low Back Pain** lasting at least (3 or 7) days?

\_\_\_\_\_ Years \_\_\_\_\_ Months \_\_\_\_\_ Weeks \_\_\_\_\_ Days

c. How long did that **most recent** episode lasting at least (3 or 7) days last?

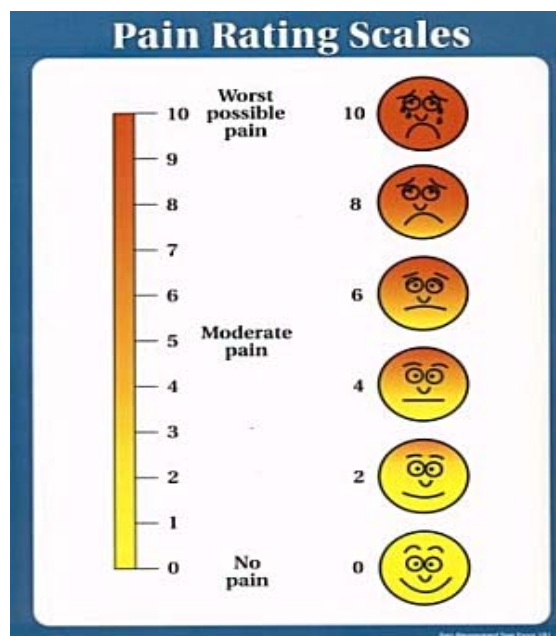
\_\_\_\_\_ Years \_\_\_\_\_

Months

\_\_\_\_\_ Weeks

\_\_\_\_\_ Days

66. What was the worst **Low Back Pain** you ever experienced? (please refer to pain scale below)



\_\_\_\_\_/10

67. How long was the longest episode of **Low Back Pain** that you EVER experienced?

\_\_\_\_ Months \_\_\_\_ Weeks \_\_\_\_ Days

68. Which of the following treatments or tests have you EVER had for **Low Back**? (check all that apply)

Treatment option	Yes	No	Approximate number of appointments or times
Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.)			Appts.
Chiropractor			Appts.
Physical Therapy (P.T.)			Appts.
Massage Therapist			Appts.
Plain X-Ray			x-ray series
Magnetic Resonance Image (MRI)			MRI scans
Computed Tomography Imaging (CT Scan, CAT Scan)			CT scans
Over the Counter Medications (e.g. Tylenol, Aspirin, Advil, etc.)			Courses of medication
Prescription Non-Narcotic Medications (e.g. prescription of Ibuprophen/Motrin, Vioxx, Celebrex, etc.)			Rx
Prescription of Narcotic Medications (e.g. Lortab, Tylenol with Codeine, Vicodin, etc.)			Rx
Epidural Cortisone Injections			Injx

Work Hardening			Rx for WH
Back Belt / Back Braces			Back Belt / Braces
I don't recall			
No Treatment			

If "Yes" to question 5 then participants will not see questions 11.

69. Have you ever had **Low Back Pain** that lasted **at least 24 hours**? \_\_\_\_ Yes \_\_\_\_ No

- a. If yes, did you see a doctor (MD, DO, or Chiropractor) for these back pain(s)? \_\_\_\_ Yes  
\_\_\_\_ No

If answer to question 11 is "No", skip to question 15.

70. Not including car or other accidents, did you ever miss work because of **Low Back Pain** you thought was from work?

\_\_\_\_ Yes \_\_\_\_ No

- a. If yes, approximately how many days have you missed for **Low Back Pain** altogether?  
\_\_\_\_ days
- b. What was the longest period of time you missed work because of **Low Back Pain**?  
\_\_\_\_ Months \_\_\_\_ Weeks \_\_\_\_ Days
- c. Did you report the **Low Back Pain** to your employer?  
\_\_\_\_ Yes \_\_\_\_ No

71. Not including car or other accidents, have you ever been on light / restricted / modified duty to **Low Back Pain**?

\_\_\_\_ Yes \_\_\_\_ No

- a. If yes, approximately how many days have you been on light / restricted / modified duty for **Low Back Pain** altogether?  
\_\_\_\_ Months \_\_\_\_ Weeks \_\_\_\_ Days
- b. What was the longest period of time you were on light / restricted / modified duty for **Low Back Pain**?  
\_\_\_\_ Months \_\_\_\_ Weeks \_\_\_\_ Days

72. Not including car or other accidents have you ever changed jobs because of **Low Back Pain** other than temporary assignments?

\_\_\_\_ Yes \_\_\_\_ No

**The following questions ask about your history of MIDDLE BACK PAIN in your life.**

73. Have you EVER had pain in your **Middle Back Pain** that lasted at least 3 days?

\_\_\_\_\_ Yes \_\_\_\_\_ No

If answer to question 14 is no, skip to question 23.

74. About how old were you when you first experienced **Middle Back Pain** that lasted at least 3 days?

\_\_\_\_\_ years old

75. How many episodes of **Middle Back Pain** have you ever had lasting at least 3 days?

\_\_\_\_\_ episodes

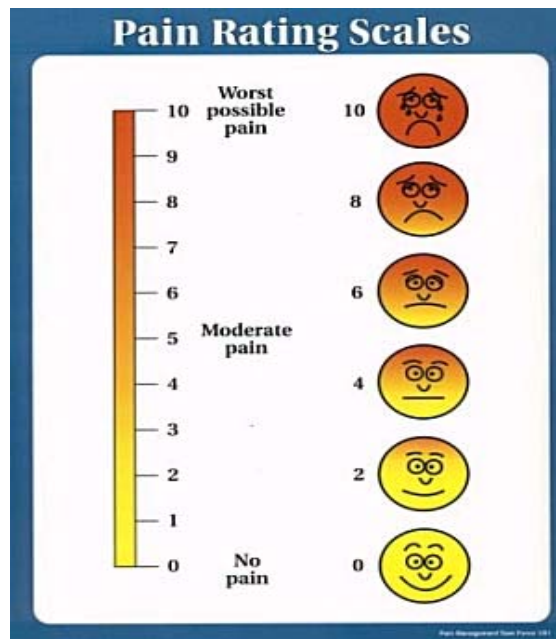
a. Approximately how many of those (answer from #16) episodes lasted at least 7 days?

\_\_\_\_\_ episodes

b. Approximately how many of those episodes (answer from #16 A) lasting at least 7 days do you estimate were work-related? \_\_\_\_\_ episodes

76. What was the worst **Middle Back Pain** you ever experienced? (please refer to pain scale below)

\_\_\_\_\_/10



How long was the longest episode of **Middle Back Pain** that you EVER experienced?

\_\_\_\_ Months \_\_\_\_ Weeks \_\_\_\_ Days

77. Which of the following treatments or tests have you EVER had for **Middle Back**? (check all that apply)

Treatment option	Yes	No	Approximate number of appointments or times
Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.)			Appts.
Chiropractor			Appts.
Physical Therapy (P.T.)			Appts.
Massage Therapist			Appts.
Plain X-Ray			x-ray series
Magnetic Resonance Image (MRI)			MRI scans
Computed Tomography Imaging (CT Scan, CAT Scan)			CT scans
Over the Counter Medications (e.g. Tylenol, Aspirin, Advil, etc.)			Courses of medication
Prescription Non-Narcotic Medications (e.g. prescription of Ibuprophen/Motrin, Vioxx, Celebrex, etc.)			Rx
Prescription of Narcotic Medications (e.g. Lortab, Tylenol with Codeine, Vicodin, etc.)			Rx
Epidural Cortisone Injections			Injx
Work Hardening			Rx for WH
Back Belt / Back Braces			Back Belt / Braces
I don't recall			
No Treatment			

78. Not including car or other accidents, did you ever miss work because of **Middle Back Pain** you thought was from work?

\_\_\_\_ Yes \_\_\_\_ No

a. If yes, approximately how many days have you missed for **Middle Back Pain** altogether?  
\_\_\_\_ days

b. What was the longest period of time you missed work because of **Middle Back Pain**?  
\_\_\_\_ Months \_\_\_\_ Weeks \_\_\_\_ Days

c. Did you report the **Middle Back Pain** to your employer?  
\_\_\_\_ Yes \_\_\_\_ No

79. Not including car or other accidents, have you ever been on light / restricted / modified duty to **Middle Back Pain**?

\_\_\_\_ Yes \_\_\_\_ No

- a. If yes, approximately how many days have you been on light / restricted / modified duty for **Middle Back Pain** altogether?

\_\_\_\_ Months \_\_\_\_ Weeks \_\_\_\_ Days

- b. What was the longest period of time you were on light / restricted / modified duty for **Middle Back Pain**?

\_\_\_\_ Months \_\_\_\_ Weeks \_\_\_\_ Days

Not including car or other accidents have you ever changed jobs because of **Middle Back Pain** other than temporary assignments?

\_\_\_\_ Yes \_\_\_\_ No

**The following questions ask about your history of NECK PAIN in your life.**

80. Have you EVER had pain in your **Neck Pain** that lasted at least 3 days?

\_\_\_\_ Yes \_\_\_\_ No

If answer to question 23 is no, skip to question 32.

81. About how old were you when you first experienced **Neck Pain** that lasted at least 3 days?

\_\_\_\_ years old

82. How many episodes of **Neck Pain** have you ever had lasting at least 3 days?

\_\_\_\_ episodes

- a. Approximately how many of those (answer from #25) episodes lasted at least 7 days?

\_\_\_\_ episodes

- b. Approximately how many of those episodes (answer from #25 A) lasting at least 7 days do you estimate were work-related? \_\_\_\_ episodes

- c. How long ago was your **most recent** episode of **Neck Pain** lasting at least 7 days?

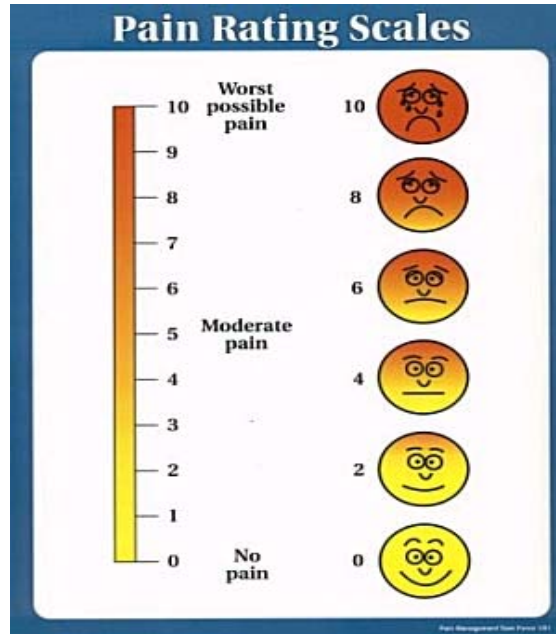
\_\_\_\_ Years \_\_\_\_ Months \_\_\_\_ Weeks \_\_\_\_ Days

- d. How long did that **most recent** episode lasting at least 7 days last?

\_\_\_\_ Years \_\_\_\_ Months \_\_\_\_ Weeks \_\_\_\_ Days

83. What was the worst **Neck Pain** you ever experienced? (please refer to pain scale below)

\_\_\_\_\_/10



How long was the longest episode of **Neck Pain** that you EVER experienced?  
 \_\_\_\_ Months \_\_\_\_ Weeks \_\_\_\_ Days

84. Which of the following treatments or tests have you EVER had for **Neck Pain**? (check all that apply)

Treatment option	Yes	No	Approximate number of appointments or times
Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.)			Appts.
Chiropractor			Appts.
Physical Therapy (P.T.)			Appts.
Massage Therapist			Appts.
Plain X-Ray			x-ray series
Magnetic Resonance Image (MRI)			MRI scans
Computed Tomography Imaging (CT Scan, CAT Scan)			CT scans
Over the Counter Medications (e.g. Tylenol, Aspirin, Advil, etc.)			Courses of medication
Prescription Non-Narcotic Medications (e.g. prescription of Ibuprophen/Motrin, Vioxx, Celebrex, etc.)			Rx
Prescription of Narcotic Medications (e.g. Lortab, Tylenol with Codeine, Vicodin, etc.)			Rx

Epidural Cortisone Injections			Injx
Work Hardening			Rx for WH
Back Belt / Back Braces			Back Belt / Braces
I don't recall			
No Treatment			

85. Not including car or other accidents, did you ever miss work because of **Neck Pain** you thought was from work?

\_\_\_\_\_ Yes \_\_\_\_\_ No

a. If yes, approximately how many days have you missed for **Neck Pain** altogether?  
\_\_\_\_\_ days

b. What was the longest period of time you missed work because of **Neck Pain**?  
\_\_\_\_\_ Months \_\_\_\_\_ Weeks \_\_\_\_\_ Days

c. Did you report the **Neck Pain** to your employer?  
\_\_\_\_\_ Yes \_\_\_\_\_ No

86. Not including car or other accidents, have you ever been on light / restricted / modified duty to **Neck Pain**?

\_\_\_\_\_ Yes \_\_\_\_\_ No

a. If yes, approximately how many days have you been on light / restricted / modified duty for **Neck Pain** altogether?  
\_\_\_\_\_ Months \_\_\_\_\_ Weeks \_\_\_\_\_ Days

b. What was the longest period of time you were on light / restricted / modified duty for **Neck Pain**?  
\_\_\_\_\_ Months \_\_\_\_\_ Weeks \_\_\_\_\_ Days

87. Not including car or other accidents have you ever changed jobs because of **Neck Pain** other than temporary assignments? \_\_\_\_\_ Yes \_\_\_\_\_ No



## 88. PAIN ASSESSMENT

At the current time or at any time in the **past month** have you had any pain, ache, and/or burning, in any of the following body parts? (check all that apply and refer to the body diagram so the worker can note all areas that apply).

Body part	Yes	No	Pain / Ache / Burning in this body part	Average Pain Severity Rating (0-10)	Current (today) Pain / Ache / Burning Symptoms	Total Pain Duration (could be >30 days... e.g. 365 for 1 year)
Neck (A)					<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
Shoulder(s)						
Interscapular (F)			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
R. Nape of the Neck (C)			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
R. Periscapular (G)			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
R. Shoulder (Glenohumeral) (H)			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
R. Upper Arm (K)			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
L. Nape of the Neck (B)			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
L. Periscapular (E)			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
L. Shoulder (Glenohumeral) (D)			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
L. Upper Arm (I)			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
Middle Back (J)			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
Lower Back						
Lumbar Immediately Paraspinal (M)			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
R. Lumbar (N)			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
L. Lumbar (L)			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
R. Gluteal (P)			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
L. Gluteal (O)			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
Legs						
R. Thigh (R)			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
L. Thigh (Q)			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
R. Upper Calf (T)			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days

Need to fill out pain diagram

L. Upper Calf (S)			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
R. Lower Calf/foot (V)			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
L. Lower Calf/foot (U)			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days

a. If yes, which of the above, if any, were from an accident (e.g. a car accident, slip, trip, fall, etc.)?

89. Have you ever had pain in the lower back or buttock that traveled down a leg into a calf?

\_\_\_\_ Yes \_\_\_\_ No \_\_\_\_ Right \_\_\_\_ Left \_\_\_\_ Both at the same time \_\_\_\_ Both legs at different times

a. If yes, at it's longest, approximately how long did this type of pain last (mark only if pain in that leg)?

**Right:** \_\_\_\_ Days \_\_\_\_ Weeks \_\_\_\_ Months \_\_\_\_ Years **Left:** \_\_\_\_ Days \_\_\_\_ Weeks \_\_\_\_ Months \_\_\_\_ Years

90. Did you have numbness and/or tingling in either of your legs **in the past month**? Yes \_\_\_\_ No \_\_\_\_

a. If yes, please mark where in the table below (mark all that apply).

	Yes	No	Left	Right
Thigh (Q & R)				
Lateral Calf (W & Z)				
Medial Calf (X & Y)				
Foot				
Toes				

91. Did the tingling and/or numbness occur at the same time as low back pain? Yes \_\_\_\_ No \_\_\_\_

92. Did the tingling and/or numbness occur only with sitting on a leg and causing it to "fall asleep"?

Yes \_\_\_\_ No \_\_\_\_

93. Have you ever received workers compensation for time off work for a work related injury, whether for the back or any other part of the body? \_\_\_\_ Yes \_\_\_\_ No
- a. If yes, was it for a back related injury? \_\_\_\_ Yes \_\_\_\_ No

### A.3. Physical Examination

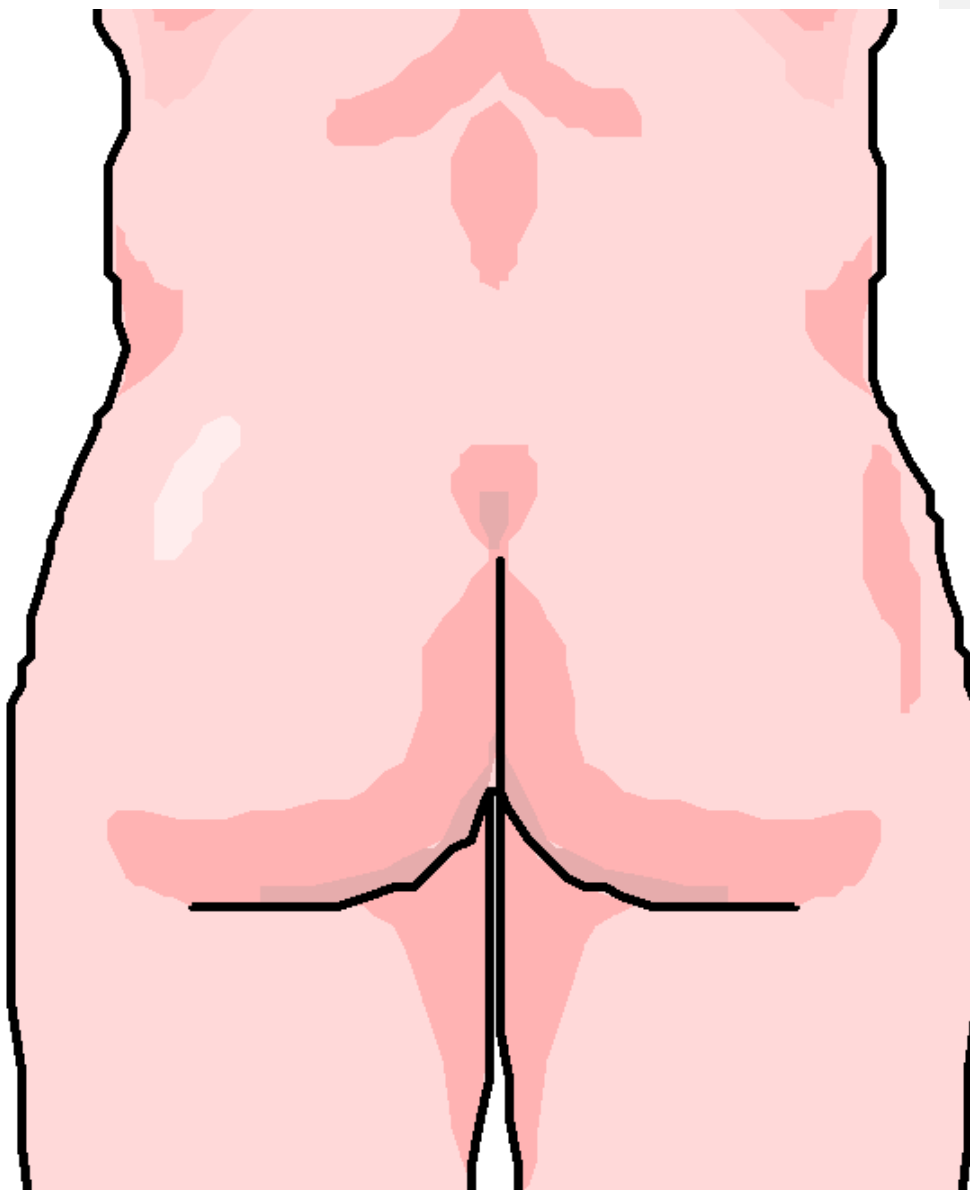
#### Structured Interview Low Back Pain Diagram #1

##### Typical Low Back Pain in the past month

This is to be completed by anyone indicating pain in Lumbar Immediately Paraspinal (M), Right Lumbar (N) Left Lumbar (L), Right Gluteal (P), and/or Left Gluteal (O)

94. Circle the area of the low back where you typically experienced pain in the past month.

95. Mark with an "X" on the diagram where you experienced the WORST pain.



**Back Vital Statistics Data Collection**

Plant: \_\_\_\_\_

Subject ID # \_\_\_\_\_

Date: \_\_\_\_\_

1. Heart Rate \_\_\_\_\_ beats/min

2. Blood Pressure \_\_\_\_\_ mmHg / \_\_\_\_\_ mmHg  
Systolic Diastolic

Test	Yes	No
R. Foot Only Toe Raise 10 Times (able to complete task?)		
L. Foot Only Toe Raise 10 Times (able to complete task?)		
Heel Walk 5 Paces on each leg (able to complete task?)		
Toe Walk 5 Paces on each leg (able to complete task?)		

3. Gait (10 paces) \_\_\_ Normal \_\_\_ Antalgic  
\_\_\_ Other describe: \_\_\_\_\_

4. Chest Circumference \_\_\_\_\_ cm

5. Waist Circumference \_\_\_\_\_ cm

6. Hip Circumference \_\_\_\_\_ cm

7. Measured Middle Finger fingertip to floor distance (knees locked, without shoes)

Finger	Neutral Upright	Lateral Flexion	Forward Spinal Flexion
Right (cm)			
Left (cm)			

8. Goniometer measurements (landmarks are greater Trochanter to the posterior acromion process and middle knee joint)

- a. Neutral \_\_\_\_\_ degrees
- b. Full Flexion \_\_\_\_\_ degrees
- c. Full Extension \_\_\_\_\_ degrees

9. Measured Weight (Without Shoes) \_\_\_\_\_ kg

10. Measured Height (Without Shoes) \_\_\_\_\_ cm

11. Shoulder Width (Lateral Posterior Acromion process tip to Lateral P. Acromion process)  
\_\_\_\_\_ cm

12. Hip to Shoulder length (Lateral Iliac crest to Posterior Acromion Process) \_\_\_\_\_ cm

13. Upper Arm length (Posterior Acromion Process to Upper Olecranon Process) \_\_\_\_\_ cm

14. Lower Arm length (Upper Olecranon Process to distal 3<sup>rd</sup> MCP joint) \_\_\_\_\_ cm

15. Horizontal Arm Length (Horizontal From Posterior Acromion to distal 3<sup>rd</sup> MCP Joint)  
\_\_\_\_\_ cm
16. Elbow Height (Upper Olecranon Process to floor, **with shoes**) \_\_\_\_\_ cm
17. Knee Height (Upper patella to floor, **with shoes**) \_\_\_\_\_ cm

# Back Physical Examination Form (all physicals)

Plant: \_\_\_\_\_

Subject ID # \_\_\_\_\_

Date: \_\_\_\_\_

Body region	Sign	1st Examiner		2nd Examiner	
		+	-	+	-
		Present	Absent	Present	Absent
Neck (seated)	R. Spurlings (Right Neck Rotation)				
	L. Spurlings (Left Neck Rotation)				
	Abnormal Cervical ROM (Flexion less than 2 cm from the sternum)				
	Evidence of Neck Surgery / Scar (Anterior or Posterior)				
	Superficial Neck Tenderness				
	General Overreaction to Examination				
Neck (seated)	Simulated Axial Loading				
Back (seated)	Simulated Axial Loading				

Lumbar Back	Seated Physical Exam Maneuver	+	-	+	-
		Present	Absent	Present	Absent
	R. “+” <b>Seated</b> Straight Leg Raise (Leg Pain below the knee not hamstring tightness, 60° or less)				
	L. “+” <b>Seated</b> Straight Leg Raise (Leg Pain below the knee not hamstring tightness, 60° or less)				

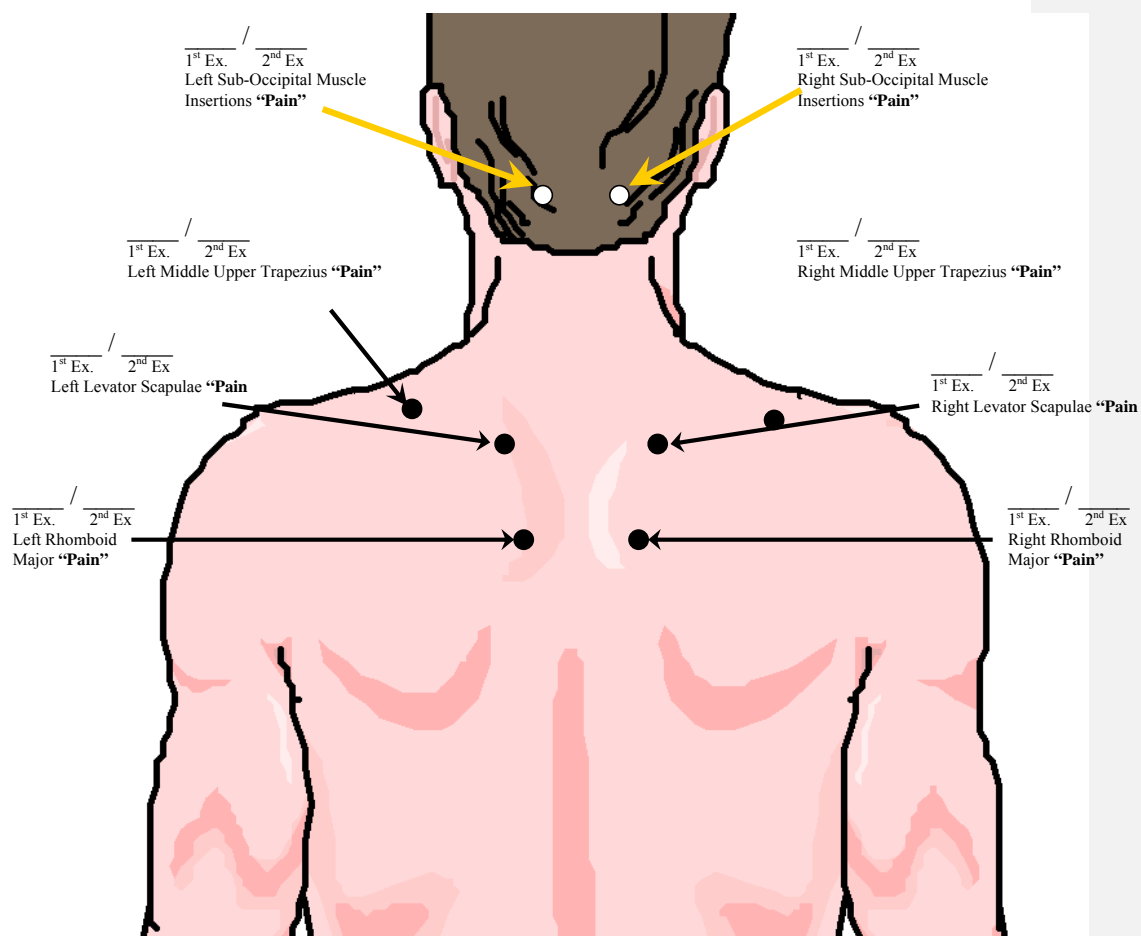
Seated Test	1 <sup>st</sup> Examiner	2 <sup>nd</sup> Examiner
R. Patellar Tendon Reflex Grade (0 - 4+)		
L. Patellar Tendon Reflex Grade (0 - 4+)		
R. Achilles Tendon Reflex Grade (0 – 4+)		
L. Achilles Tendon Reflex Grade (0 – 4+)		
R. Extensor Hallicus Muscle Strength Grade (1-5 / 5)	/ 5	/ 5
L. Extensor Hallicus Muscle Strength Grade (1-5 / 5)	/ 5	/ 5

Lumbar Back	Physical Exam Maneuver	+	-	+	-
		Present	Absent	Present	Absent
(recumbent)	R. “+” <b>Recumbent</b> Straight Leg Raise (Leg Pain, ≤ 60° )				
	L. “+” <b>Recumbent</b> Straight Leg Raise (Leg Pain, ≤ 60° )				
	R. Sacroiliac Joint Stress Test				
	L. Sacroiliac Joint Stress Test				

(standing)	Simulated Rotation (20 to 30 degrees)				
	General Overreaction to Low Back Examination				
	Superficial Low Back Tenderness				
	Evidence of back surgery / scar				

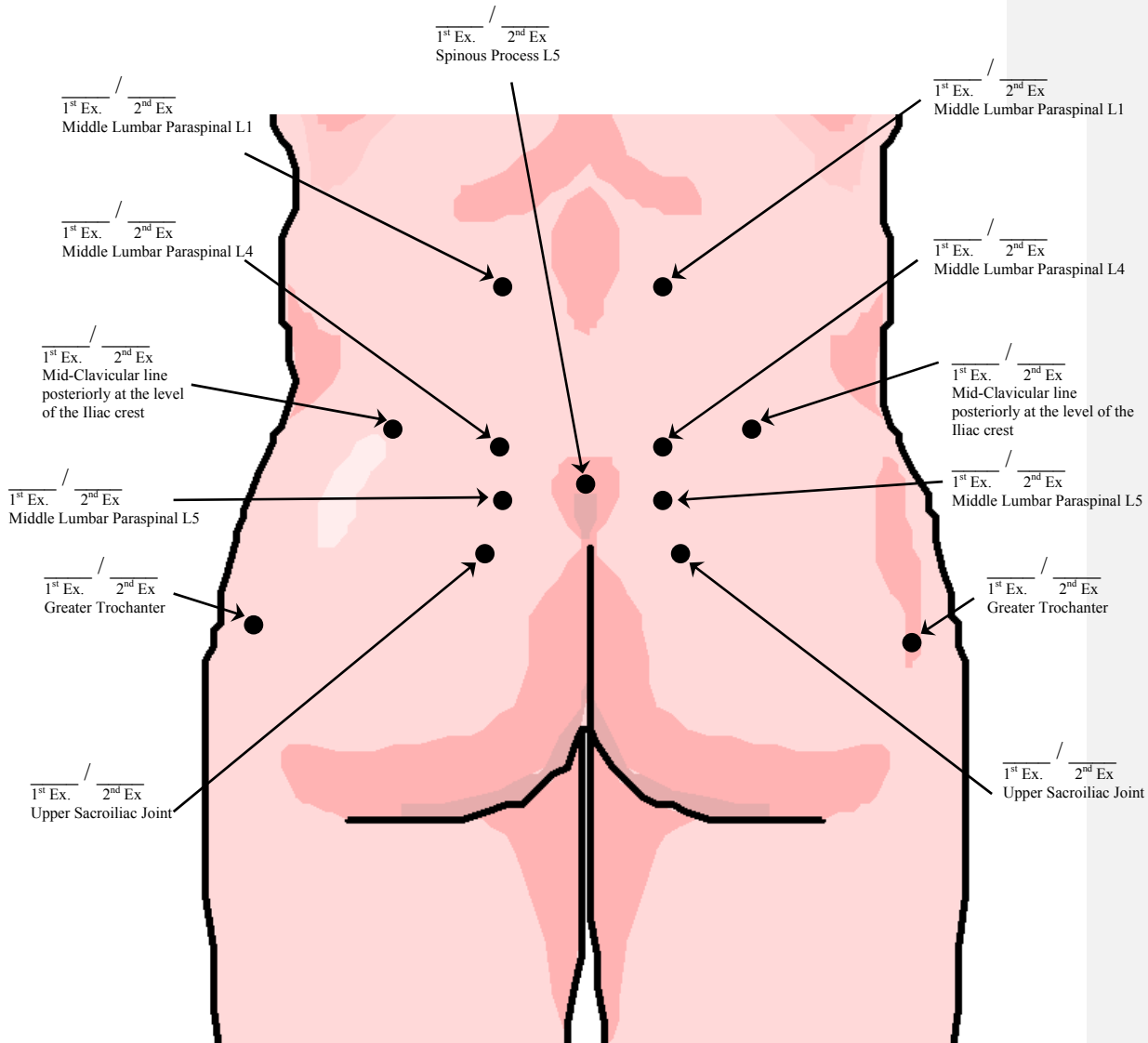
## Neck Pain Tender Point Evaluation

Directions: Using 4 kg of force, evaluate all tender points, checking all points where “**pain**” is indicated. **Circle the MOST PAINFUL** of all tender points in the neck (if any).





Directions: Using 4 kg of force, evaluate all tender points, checking all points where "pain" is indicated. **Circle the MOST PAINFUL** of all tender points in the Low Back (if any).



18. Signs of Rheumatoid Arthritis      \_\_\_\_ Yes \_\_\_\_ No

19. Heberden's Nodes      \_\_\_\_ Yes \_\_\_\_ No  
If yes, which joint(s) \_\_\_\_\_

20. Bouchard's Nodes      \_\_\_\_ Yes \_\_\_\_ No  
If yes, which joint(s) \_\_\_\_\_

Other findings in the physical exam (e.g. Sensory Exam If Indicated):

Body Part	Test performed	Positive finding	Negative finding	Examiner	
				1 <sup>st</sup>	2 <sup>nd</sup>

### **Overall Diagnostic Impression**

(check appropriate boxes)

	Yes	No
Past history of <b>Right</b> sciatica	Right	
Past history of <b>Left</b> sciatica		
Current history of <b>Right</b> sciatica ( <b>L5</b> Nerve Root)	Right	
Current history of <b>Left</b> sciatica ( <b>L5</b> Nerve Root)		
Current history of <b>Right</b> sciatica ( <b>S1</b> Nerve Root)	Right	
Current history of <b>Left</b> sciatica ( <b>S1</b> Nerve Root)		
Past history of Low Back Pain lasting at least 7 days		
Current history of Low Back Pain lasting at least 7 days		
Other (describe)		
Other (describe)		

#### A.4. Monthly Follow-up

Gender: \_\_\_\_\_  
Date: \_\_\_\_\_  
Last Visit Date : \_\_\_\_\_  
Days Since Last Visit: \_\_\_\_\_  
Time: \_\_\_\_\_  
Plant: \_\_\_\_\_  
Subject ID: \_\_\_\_\_

#### Low Back Pain Monthly Questionnaire (to be completed on a laptop computer)

1. Absent \_\_\_\_\_ Yes \_\_\_\_\_ No

*If Yes, Why is the participant absent? (Please circle all that apply).*

Ill / sick, Vacation, FMLA, Surgery / Medical Appt, Laid off, Terminated,  
Quit,  
Declined Participation, Declined participation (this month only), OTHER....

*If quit, terminated, or laid off, when was their last day here?*

\_\_\_\_\_  
MM / DD / YYYY

#### 2. Last time we were here you had pain in:

All areas of pain from previous month will be checked and previous pain rating present.

<input checked="" type="checkbox"/>	Body Part	Previous Pain Rating	Did it go away?	Is it the same?	Present Pain Rating?	Percent of days you have pain?	If the pain stopped how many days ago did it stop?
<input type="checkbox"/>	Lumbar Immediately Paraspinal (M)		Yes /No	Yes /No			
<input type="checkbox"/>	R. Lumbar (N)		Yes /No	Yes /No			
<input type="checkbox"/>	L. Lumbar (L)		Yes /No	Yes /No			
<input type="checkbox"/>	R. Gluteal (P)		Yes /No	Yes /No			
<input type="checkbox"/>	L. Gluteal (O)		Yes /No	Yes /No			
<input type="checkbox"/>	R. Thigh (R)		Yes /No	Yes /No			
<input type="checkbox"/>	L. Thigh (Q)		Yes /No	Yes /No			

<input type="checkbox"/>	R. Upper Calf (T)		Yes /No	Yes /No			
<input type="checkbox"/>	L. Upper Calf (S)		Yes /No	Yes /No			
<input type="checkbox"/>	R. Lower Calf/foot (V)		Yes /No	Yes /No			
<input type="checkbox"/>	L. Lower Calf/foot (U)		Yes /No	Yes /No			

3. Last time we were here you had numbness and tingling in:

Previous percent of days will be filled in.

<input checked="" type="checkbox"/>	Body Part	Previous % of days	Did it go away?	Is it the same?	Precent of days you have N/T?	Does the N/T occur at the same time as the low back pain?	
<input type="checkbox"/>	R. Thigh (R)		Yes / No			Yes / No	
<input type="checkbox"/>	R. Lateral Calf (Z)		Yes / No			Yes / No	
<input type="checkbox"/>	R. Medial Calf (Y)		Yes / No			Yes / No	
<input type="checkbox"/>	R. Foot (S)		Yes / No			Yes / No	
<input type="checkbox"/>	R. Toes (U)		Yes / No			Yes / No	
<input type="checkbox"/>	L. Thigh (Q)		Yes / No			Yes / No	
<input type="checkbox"/>	L. Lateral Calf (W)		Yes / No			Yes / No	
<input type="checkbox"/>	L. Medial Calf (X)		Yes / No			Yes / No	
<input type="checkbox"/>	L. Foot (T)		Yes / No			Yes / No	
<input type="checkbox"/>	L. Toes (V)		Yes / No			Yes / No	

4. Do you have any NEW PAIN since your last follow-up      days ago in your

Body part	Pain / Ache / Burning in this body part	Average Pain Severity Rating (0-10)	Current (today) Pain / Ache / Burning Symptoms	Total Pain Duration
Lumbar Immediately Paraspinal (M)	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
R. Lumbar (N)	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
L. Lumber (L)	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days

R. Gluteal ( <b>P</b> )	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		Days
L. Gluteal ( <b>O</b> )	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		Days
Legs					
R. Thigh ( <b>R</b> )	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		Days
L. Thigh ( <b>Q</b> )	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		Days
R. Upper Calf ( <b>T</b> )	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		Days
L. Upper Calf ( <b>S</b> )	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		Days
R. Lower Calf/foot ( <b>V</b> )	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		Days
L. Lower Calf/foot ( <b>U</b> )	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		Days

**PLEASE FILL OUT PAIN DIAGRAM FOR YOUR NEW LOW BACK**

5. What do you think caused this New Pain?

- ☐ Unsure  
☐ Accident outside of work (slip, trip, fall, MVA, etc.)  
☐ Something outside of work (NOT an accident)  
☐ Accident at work (slip, trip, fall, MVA, etc.)  
☐ Something at work (Not an accident)  
☐ Relapse or aggravation of previously reported pain

6. When did the Pain occur?

- (Don't answer if cause ="Unsure"  
☐ Sudden (within 30 minutes)  
☐ Same day (after 30 minutes)  
☐ Next day or after  
☐ Don't Know

7. Did a job evaluation team study the part of your job related to when/where you were injured?

- ☐ Yes  
☐ No  
☐ Not Applicable

8. Do you have any new NUMBNESS/TINGLING in your:

<input checked="" type="checkbox"/>	Body Part	Number of days you have had N/T.	How often do you have N/T upon awakening in the morning?	How often do you have N/T at night?
<input type="checkbox"/>	R. Thigh (R)			

<input type="checkbox"/>	R. Lateral Calf (Z)			
<input type="checkbox"/>	R. Medial Calf (Y)			
<input type="checkbox"/>	R. Foot (S)			
<input type="checkbox"/>	R. Toes (U)			
<input type="checkbox"/>	L. Thigh (Q)			
<input type="checkbox"/>	L. Lateral Calf (W)			
<input type="checkbox"/>	L. Medial Calf (X)			
<input type="checkbox"/>	L. Foot (T)			
<input type="checkbox"/>	L. Toes (V)			

9. What do you think caused this NUMBNESS/TINGLING?

- ☐ Unsure  
☐ Accident outside of work (slip, trip, fall, MVA, etc.)  
☐ Something outside of work (NOT an accident)  
☐ Accident at work (slip, trip, fall, MVA, etc.)  
☐ Something at work (Not an accident)  
☐ Relapse or aggravation of previously reported pain

10. When did the Numbness/Tingling occur?

- (Don't answer if cause = "Unsure"  
☐ Sudden (within 30 minutes)  
☐ Same day (after 30 minutes)  
☐ Next day or after  
☐ Don't Know

11. Does the N/T occur at the same time as the low back pain?

- ☐ Yes  
☐ No

12. Since your follow-up \_\_\_\_ days ago, have you been on light duty because of Low Back Pain?

- ☐ Yes  
☐ No

If yes, How many days ago or what day did you begin light duty?

\_\_\_\_ month \_\_\_\_ day \_\_\_\_ year \_\_\_\_ days ago

When did you end or will you end working light duty?

\_\_\_\_ month \_\_\_\_ day \_\_\_\_ year

13. Since your last follow-up \_\_\_\_ days ago, have you had any lost duty days due to Low Back Pain?

\_\_\_\_ Yes

\_\_\_\_ No

If Yes, How many lost duty days did you have?

\_\_\_\_ days

14. Are you taking any medication or getting any treatment for your pain or numbness/tingling?

\_\_\_\_ Yes

\_\_\_\_ No

**If YES, What types of treatment are you using?**

<input checked="" type="checkbox"/>	<b>Mid-Back</b>	Yes / No
<input type="checkbox"/>	Back Surgery	
<input type="checkbox"/>	Injection in the back	
<input type="checkbox"/>	Back Brace	
<input type="checkbox"/>	Chiropractor	
<input type="checkbox"/>	Physician	
<input type="checkbox"/>	PT or OT	
<input checked="" type="checkbox"/>	<b>Low Back</b>	Yes / No
<input type="checkbox"/>	Back Surgery	Yes / No
<input type="checkbox"/>	Injection in the back	Yes / No
<input type="checkbox"/>	Back Brace	Yes / No

<input type="checkbox"/>	Chiropractor	Yes / No
<input type="checkbox"/>	Physician	Yes / No
<input type="checkbox"/>	PT or OT	Yes / No
	<b>Other</b>	
<input type="checkbox"/>	NSAID or OTC Meds	Yes / No
<input type="checkbox"/>	Prescription Meds not NSAID or Narcotic	Yes / No
<input type="checkbox"/>	Prescription, Narcotic / painkillers	Yes / No
<input type="checkbox"/>	Light Duty	Yes / No
<input type="checkbox"/>	Aerobic Exercise	Yes / No
<input type="checkbox"/>	Strength Exercise	Yes / No
<input type="checkbox"/>	Stretching	Yes / No
<input type="checkbox"/>	Other	Yes / No
<input type="checkbox"/>	Other	Yes / No

15. Since we saw you \_\_\_\_\_ days ago, Have you:

Changed jobs / lines	Yes/No
Changed the number of hours you work	Yes / No
Started using new / different equipment	Yes / No
Changed your rotation schedule	Yes / No
Dhanged your production rate	Yes / No
Other	Yes / No

16. Does the participant complain of a “tired back” even though there is no new or recurrent Low Back Pain?

\_\_\_\_\_ Yes

\_\_\_\_\_ No

17. If you were absent at our last follow-up visit, what day did you return to work?

Month                      Day                      Year



18. If you were not here the last time we collected monthly follow-up data, why were you absent?

☐ ill

☐ Vacation

☐ Pregnancy

☐ Light Duty

☐ Injury

☐ Surgery or medical appt.

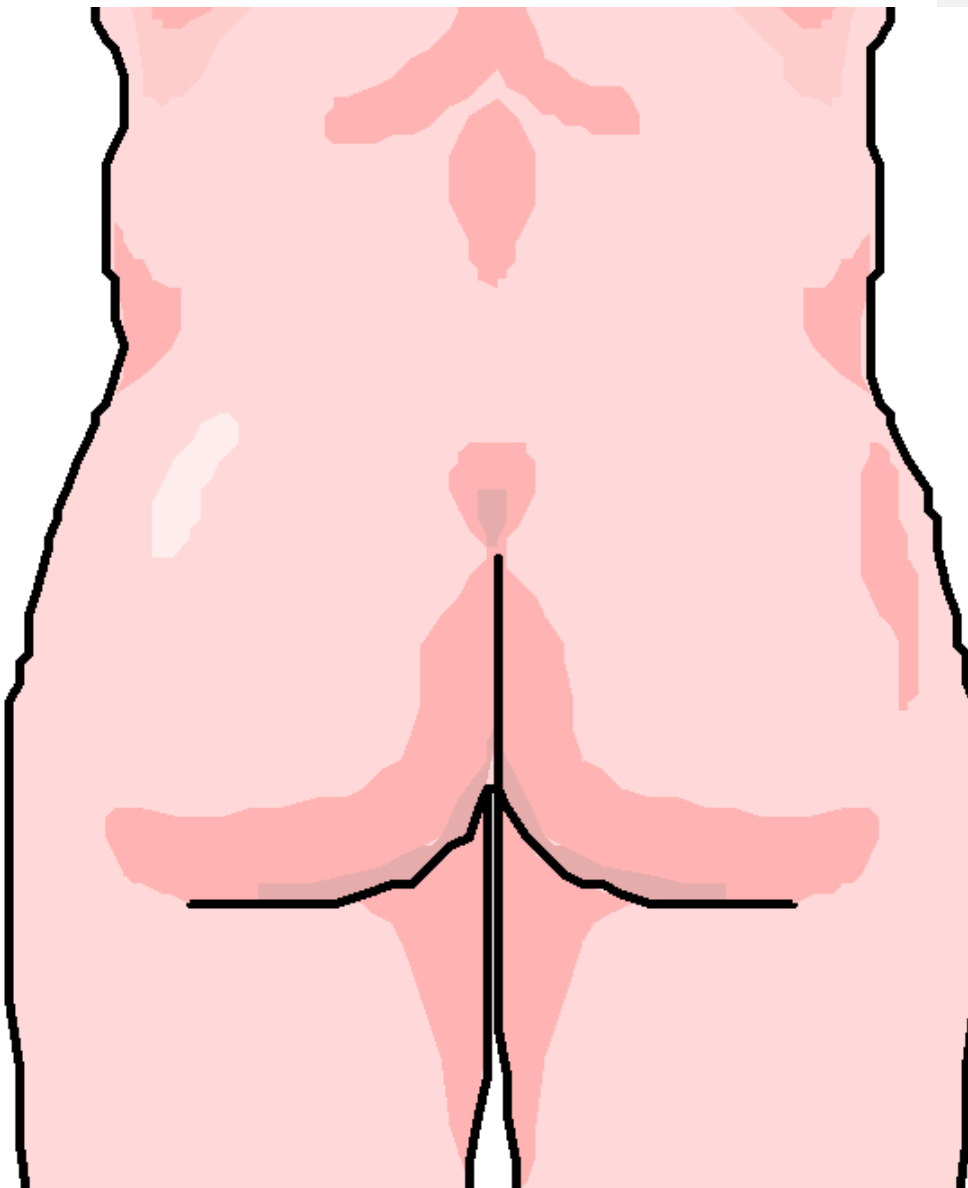
☐ Other

## Monthly Follow-Up Low Back Pain Diagram #1

### Typical Low Back Pain in the past month

This is to be completed by anyone indicating pain in Lumbar Immediately Paraspinal (**M**), Right Lumbar (**N**) Left Lumbar (**L**), Right Gluteal (**P**), and/or Left Gluteal (**O**)

96. Circle the area of the low back where you typically experienced pain in the past month.
97. Mark with an "X" on the diagram where you experienced the WORST pain.



**Low Back Pain Monthly Questionnaire (to be completed on a laptop computer)**

19. Absent \_\_\_\_ Yes \_\_\_\_ No

*If Yes, Why is the participant absent? (Please circle all that apply).*

Ill / sick, Vacation, FMLA, Surgery / Medical Appt, Laid off, Terminated, Quit,

Declined Participation, Declined participation (this month only), OTHER....

*If quit, terminated, or laid off, when was their last day here?*

\_\_\_\_\_  
MM / DD / YYYY

**20. Last time we were here you had pain in:**

All areas of pain from previous month will be checked and previous pain rating present.

<input checked="" type="checkbox"/>	Body Part	Previous Pain Rating	Did it go away?	Is it the same?	Present Pain Rating?	Percent of days you have pain?	If the pain stopped how many days ago did it stop?
<input type="checkbox"/>	Lumbar Immediately Paraspinal (M)		Yes /No	Yes /No			
<input type="checkbox"/>	R. Lumbar (N)		Yes /No	Yes /No			
<input type="checkbox"/>	L. Lumbar (L)		Yes /No	Yes /No			
<input type="checkbox"/>	R. Gluteal (P)		Yes /No	Yes /No			
<input type="checkbox"/>	L. Gluteal (O)		Yes /No	Yes /No			
<input type="checkbox"/>	R. Thigh (R)		Yes /No	Yes /No			
<input type="checkbox"/>	L. Thigh (Q)		Yes /No	Yes /No			
<input type="checkbox"/>	R. Upper Calf (T)		Yes /No	Yes /No			
<input type="checkbox"/>	L. Upper Calf		Yes /No	Yes /No			

	(S)						
<input type="checkbox"/>	R. Lower Calf/foot (V)		Yes /No	Yes /No			
<input type="checkbox"/>	L. Lower Calf/foot (U)		Yes /No	Yes /No			

**21. Last time we were here you had numbness and tingling in:**

Previous percent of days will be filled in.

<input checked="" type="checkbox"/>	Body Part	Previous % of days	Did it go away?	Is it the same?	Precent of days you have N/T?	Does the N/T occur at the same time as the low back pain?	
<input type="checkbox"/>	R. Thigh (R)		Yes / No			Yes / No	
<input type="checkbox"/>	R. Lateral Calf (Z)		Yes / No			Yes / No	
<input type="checkbox"/>	R. Medial Calf (Y)		Yes / No			Yes / No	
<input type="checkbox"/>	R. Foot (S)		Yes / No			Yes / No	
<input type="checkbox"/>	R. Toes (U)		Yes / No			Yes / No	
<input type="checkbox"/>	L. Thigh (Q)		Yes / No			Yes / No	
<input type="checkbox"/>	L. Lateral Calf (W)		Yes / No			Yes / No	
<input type="checkbox"/>	L. Medial Calf (X)		Yes / No			Yes / No	
<input type="checkbox"/>	L. Foot (T)		Yes / No			Yes / No	
<input type="checkbox"/>	L. Toes (V)		Yes / No			Yes / No	

**22. Do you have any NEW PAIN since your last follow-up \_\_\_ days ago in your**

Body part	Pain / Ache / Burning in this body part	Average Pain Severity Rating (0-10)	Current (today) Pain / Ache / Burning Symptoms	Total Pain Duration
Lumbar Immediately Paraspinal (M)	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
R. Lumbar (N)	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
L. Lumbar (L)	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
R. Gluteal (P)	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
L. Gluteal (O)	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Days
Legs				

R. Thigh ( <b>R</b> )	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		Days
L. Thigh ( <b>Q</b> )	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		Days
R. Upper Calf ( <b>T</b> )	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		Days
L. Upper Calf ( <b>S</b> )	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		Days
R. Lower Calf/foot ( <b>V</b> )	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		Days
L. Lower Calf/foot ( <b>U</b> )	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		Days

**PLEASE FILL OUT PAIN DIAGRAM FOR YOUR NEW LOW BACK**

23. What do you think caused this New Pain?

- ☐ Unsure  
☐ Accident outside of work (slip, trip, fall, MVA, etc.)  
☐ Something outside of work (NOT an accident)  
☐ Accident at work (slip, trip, fall, MVA, etc.)  
☐ Something at work (Not an accident)  
☐ Relapse or aggravation of previously reported pain

24. When did the Pain occur?

- (Don't answer if cause = "Unsure")  
☐ Sudden (within 30 minutes)  
☐ Same day (after 30 minutes)  
☐ Next day or after  
☐ Don't Know

25. Did a job evaluation team study the part of your job related to when/where you were injured?

- ☐ Yes  
☐ No  
☐ Not Applicable

26. Do you have any new NUMBNESS/TINGLING in your:

<input checked="" type="checkbox"/>	Body Part	Number of days you have had N/T.	How often do you have N/T upon awakening in the morning?	How often do you have N/T at night?
<input type="checkbox"/>	R. Thigh (R)			
<input type="checkbox"/>	R. Lateral Calf (Z)			
<input type="checkbox"/>	R. Medial Calf (Y)			

<input type="checkbox"/>	R. Foot (S)			
<input type="checkbox"/>	R. Toes (U)			
<input type="checkbox"/>	L. Thigh (Q)			
<input type="checkbox"/>	L. Lateral Calf (W)			
<input type="checkbox"/>	L. Medial Calf (X)			
<input type="checkbox"/>	L. Foot (T)			
<input type="checkbox"/>	L. Toes (V)			

27. What do you think caused this NUMBNESS/TINGLING?

- ☐ Unsure  
☐ Accident outside of work (slip, trip, fall, MVA, etc.)  
☐ Something outside of work (NOT an accident)  
☐ Accident at work (slip, trip, fall, MVA, etc.)  
☐ Something at work (Not an accident)  
☐ Relapse or aggravation of previously reported pain

28. When did the Numbness/Tingling occur?

- (Don't answer if cause ="Unsure"  
☐ Sudden (within 30 minutes)  
☐ Same day (after 30 minutes)  
☐ Next day or after  
☐ Don't Know

29. Does the N/T occur at the same time as the low back pain?

- ☐ Yes  
☐ No

30. Since your follow-up \_\_\_\_ days ago, have you been on light duty because of Low Back Pain?

- ☐ Yes  
☐ No

If yes, How many days ago or what day did you begin light duty?

\_\_\_\_\_

month          day          year          days ago

When did you end or will you end working light duty?

\_\_\_\_\_  
month          day          year

31. Since your last follow-up \_\_\_\_ days ago, have you had any lost duty days due to Low Back Pain?

\_\_\_\_ Yes

\_\_\_\_ No

*If Yes, How many lost duty days did you have?*

\_\_\_\_ days

32. Are you taking any medication or getting any treatment for your pain or numbness/tingling?

\_\_\_\_ Yes

\_\_\_\_ No

*If YES, What types of treatment are you using?*

<input checked="" type="checkbox"/>	<b>Mid-Back</b>	Yes / No
<input type="checkbox"/>	Back Surgery	
<input type="checkbox"/>	Injection in the back	
<input type="checkbox"/>	Back Brace	
<input type="checkbox"/>	Chiropractor	
<input type="checkbox"/>	Physician	
<input type="checkbox"/>	PT or OT	
<input checked="" type="checkbox"/>	<b>Low Back</b>	Yes / No
<input type="checkbox"/>	Back Surgery	Yes / No
<input type="checkbox"/>	Injection in the back	Yes / No
<input type="checkbox"/>	Back Brace	Yes / No
<input type="checkbox"/>	Chiropractor	Yes / No

<input type="checkbox"/>	Physician	Yes / No
<input type="checkbox"/>	PT or OT	Yes / No
	<b>Other</b>	
<input type="checkbox"/>	NSAID or OTC Meds	Yes / No
<input type="checkbox"/>	Prescription Meds not NSAID or Narcotic	Yes / No
<input type="checkbox"/>	Prescription, Narcotic / painkillers	Yes / No
<input type="checkbox"/>	Light Duty	Yes / No
<input type="checkbox"/>	Aerobic Exercise	Yes / No
<input type="checkbox"/>	Strength Exercise	Yes / No
<input type="checkbox"/>	Stretching	Yes / No
<input type="checkbox"/>	Other	Yes / No
<input type="checkbox"/>	Other	Yes / No

33. Since we saw you \_\_\_\_\_ days ago, Have you:

Changed jobs / lines	Yes/No
Changed the number of hours you work	Yes / No
Started using new / different equipment	Yes / No
Changed your rotation schedule	Yes / No
Dhanged your production rate	Yes / No
Other	Yes / No

34. Does the participant complain of a “tired back” even though there is no new or recurrent Low Back Pain?

\_\_\_\_\_ Yes  
 \_\_\_\_\_ No

35. If you were absent at our last follow-up visit, what day did you return to work?

\_\_\_\_\_  
 Month                      Day                      Year



36. If you were not here the last time we collected monthly follow-up data, why were you absent?

☐ ill

☐ Vacation

☐ Pregnancy

☐ Light Duty

☐ Injury

☐ Surgery or medical appt.

☐ Other

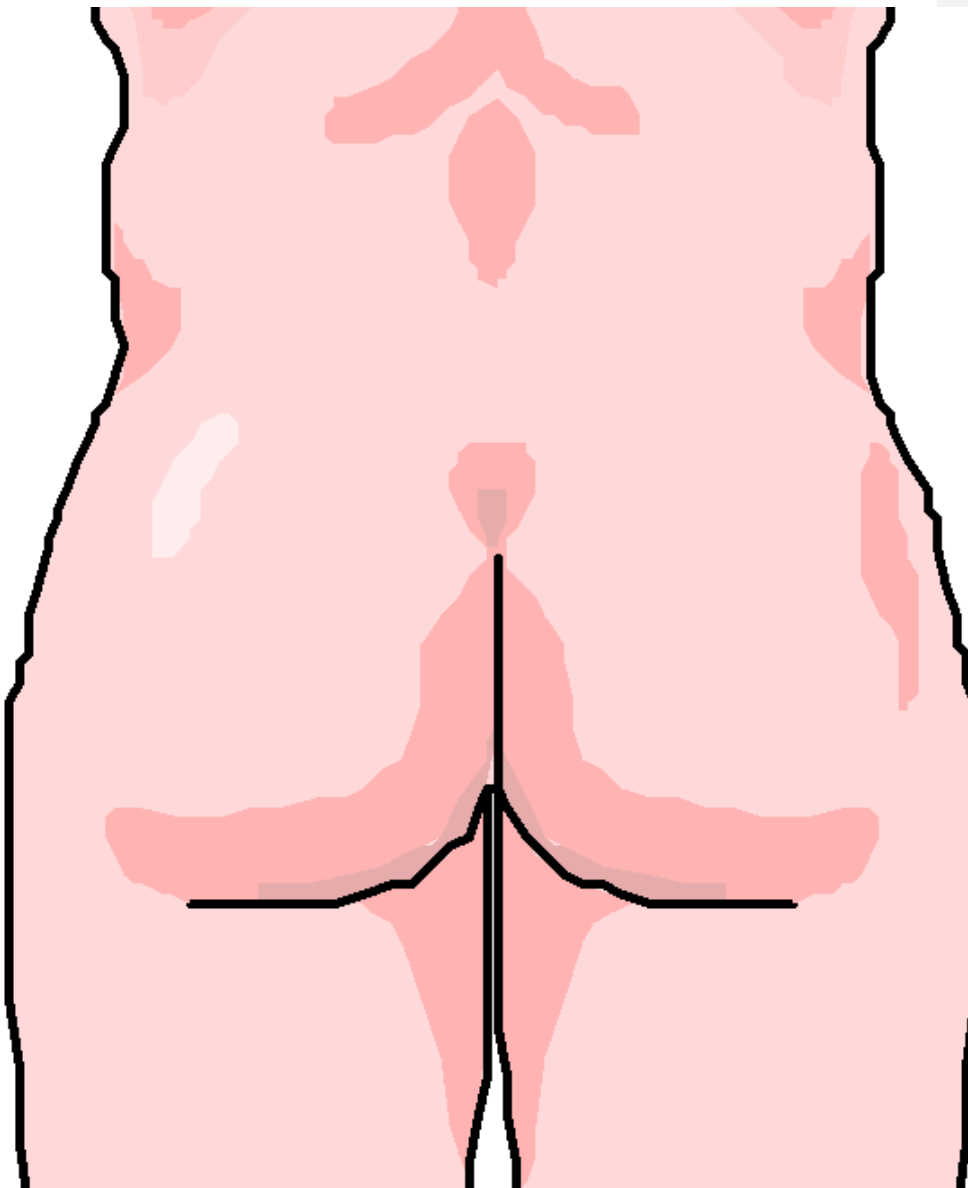
## Monthly Follow-Up Low Back Pain Diagram #1

### Typical Low Back Pain in the past month

This is to be completed by anyone indicating pain in Lumbar Immediately Paraspinal (**M**), Right Lumbar (**N**) Left Lumbar (**L**), Right Gluteal (**P**), and/or Left Gluteal (**O**)

98. Circle the area of the low back where you typically experienced pain in the past month.

99. Mark with an "X" on the diagram where you experienced the WORST pain.



## **A.5. Exit Interview**

### **An Ergonomic-Epidemiologic Study of the Distal Upper Extremity and Low Back: Exit Questionnaire**

Directions:

Please answer each question by pointing the arrow with the mouse and clicking with you index finger to either mark “yes” or “no” or to fill in a blank. If you need help or have any questions please ask one of our research assistants. We’re happy to help!

Code # \_\_\_\_\_  
Date: \_\_\_\_\_

## An Ergonomic-Epidemiologic Study of the Low Back: Baseline Questionnaire

1. Do you walk on a regular basis **at least twice a month** outside of work?  
\_\_\_\_ Yes \_\_\_\_ No

a. If yes,

Type of Exercise	Number of months per year	Average number of times per week	Average number of minutes each time
Walking	Months	Per week	Minutes

- b. Do you do any other exercise outside of work (for example, bicycling, basketball, skiing, or swimming) at least twice a month? \_\_\_\_ Yes \_\_\_\_ No

a. Which of the following types of exercise (outside of work) do you do?

Type of Exercise	Yes	No	Number of months per year	Average number of times per week	Average number of minutes each time
Aerobics, Jazzercise			Months	Per week	Minutes
Running, Jogging			Months	Per week	Minutes
Bowling			Months	Per week	Minutes
Bicycling			Months	Per week	Minutes
Swimming			Months	Per week	Minutes
Weight Lifting			Months	Per week	Minutes
Baseball			Months	Per week	Minutes
Basketball			Months	Per week	Minutes
Football			Months	Per week	Minutes
Soccer			Months	Per week	Minutes
Racquetball			Months	Per week	Minutes
Handball			Months	Per week	Minutes
Tennis			Months	Per week	Minutes

Snow Skiing or Snowboarding			Months	Per week	Minutes
Water Skiing or Wave Runner			Months	Per week	Minutes
Hunting			Months	Per week	Minutes
Fishing			Months	Per week	Minutes
Martial Arts (Karate, Judo, etc.)			Months	Per week	Minutes
Other (please list)			Months	Per week	Minutes
Other (please list)			Months	Per week	Minutes

100. Has anyone in your family (biological parents and/or siblings) ever had a pinched nerve, Sciatica, or **Lumbar Radiculopathy** in the lower back? \_\_\_\_ Yes \_\_\_\_ No

101. Has any one in your family (biological parents and/or siblings) ever been diagnosed with **Carpal Tunnel Syndrome**? \_\_\_\_ Yes \_\_\_\_ No

102. How often do you have **family problems** that irritate or bother you?

- \_\_\_\_ Never
- \_\_\_\_ Sometimes
- \_\_\_\_ Often
- \_\_\_\_ Always

103. How often during the past month have you **felt uneasy**?

- \_\_\_\_ Never
- \_\_\_\_ Sometimes
- \_\_\_\_ Often
- \_\_\_\_ Always

104. How often during the past month have **you felt tense**?

- \_\_\_\_ Never
- \_\_\_\_ Sometimes
- \_\_\_\_ Often
- \_\_\_\_ Always

105. How often during the past month have you **felt “down”, blue or depressed**?

- \_\_\_\_ Never
- \_\_\_\_ Sometimes
- \_\_\_\_ Often
- \_\_\_\_ Always

106. How often during the past month have you felt **nervous or anxious**?

- \_\_\_\_ Never
- \_\_\_\_ Sometimes
- \_\_\_\_ Often
- \_\_\_\_ Always

107. All in all, how satisfied are you with your job?

- ☐ Very satisfied
- ☐ Somewhat satisfied
- ☐ A little satisfied
- ☐ Not at all satisfied

108. I have an ache and/or pain, in any body part approximately about how often? \_\_\_\_% of days

- ☐ Never (0%)
- ☐ Rarely (0-20%)
- ☐ Sometimes (20-40%)
- ☐ About Half the Time (40-60%)
- ☐ Often (60-80%)
- ☐ Very often (80-100%)
- ☐ Always (100%)

109. How often do you take Tylenol or acetaminophen?

- a. ☐ Never or almost never (0-6 times a year)
- b. ☐ Rarely (less than once a month, 7-11 times a year)
- c. ☐ 1-4 times a month (12-50 times a year)
- d. ☐ 1-3 times a week (50-150 times a year)
- e. ☐ 4-6 times a week (150-300 times a year)
- f. ☐ Daily (7 times a week, 300-365 times a year)
- g. ☐ More than once a day (more than 365 times a year)
- h. ☐ I don't know (a research assistant will help)

i. Is this a prescription or over-the-counter?

- i. ☐ Prescription
- ii. ☐ Over the counter

110. How often do you take ibuprofen, Motrin, Advil, Naprosyn, or aspirin?

- a. ☐ Never or almost never (0-6 times a year)
- b. ☐ Rarely (less than once a month, 7-11 times a year)
- c. ☐ 1-4 times a month (12-50 times a year)
- d. ☐ 1-3 times a week (50-150 times a year)
- e. ☐ 4-6 times a week (150-300 times a year)
- f. ☐ Daily (7 times a week, 300-365 times a year)
- g. ☐ More than once a day (more than 365 times a year)
- h. ☐ I don't know (a research assistant will help)

i. Is this a prescription or over-the-counter?

- i. ☐ Prescription
- ii. ☐ Over the counter

111. How often do you take opioids such as Lortab, hydrocodone, Tramadol, Demerol or codeine?

- a. \_\_\_\_ Never or almost never (0-6 times a year)
  - b. \_\_\_\_ Rarely (less than once a month, 7-11 times a year)
  - c. \_\_\_\_ 1-4 times a month (12-50 times a year)
  - d. \_\_\_\_ 1-3 times a week (50-150 times a year)
  - e. \_\_\_\_ 4-6 times a week (150-300 times a year)
  - f. \_\_\_\_ Daily (7 times a week, 300-365 times a year)
  - g. \_\_\_\_ More than once a day (more than 365 times a year)
  - h. \_\_\_\_ I don't know (a research assistant will help)
- i. Is this a prescription or over-the-counter?
    - i. \_\_\_\_ Prescription
    - ii. \_\_\_\_ Over the counter
112. In the past **year**, have you had pain below your knee that you think is from a problem in your back?
- a. Yes, I have had pain below my knee that I think is from a problem in my back.
    - i. I would rate it a pain of \_\_\_\_/10 at its worst
  - b. No, I have not had any pain below my knee or foot in the past year that I think is from a problem in my back.
113. In the past month, have you had pain in your knee that is not related to an accident?
- a. Yes,
    - i. I would rate it a pain of \_\_\_\_/10 at its worst
  - b. No, I have not had any pain in my knee in the past month.
114. In the past month, have you had pain in your ankle or foot that is not related to an accident?
- a. Yes, in my ankle
    - i. I would rate it a pain of \_\_\_\_/10 at its worst
  - b. Yes, in my foot
    - i. I would rate it a pain of \_\_\_\_/10 at its worst
  - c. No, I have not had any pain in my ankle or foot in the past month.
115. How many times do you eat **restaurant or fast food** in a typical week? (For example Chili's<sup>TM</sup>, McDonald's<sup>TM</sup>, Burger King<sup>TM</sup>, or your local diner. Take home leftovers count twice)
- a. 0; 1; 2; 3; 4; 5; 6; 7; more than 7
116. When eating **restaurant food**, do you eat all the food served to you at one time?
- a. Never
  - b. Rarely
  - c. Occasionally
  - d. Sometimes
  - e. Often
  - f. Usually
  - g. Always

117. How many times do you typically eat breakfast in **one week** (7 days)?  
a. 0; 1; 2; 3; 4; 5; 6; 7; more than 7
118. How many times do you typically eat a serving of vegetables in **one day** (For example salad, V-8 Juice, carrots, broccoli, etc.)?  
a. 0; 1; 2; 3; 4; 5; 6; 7; more than 7
119. How many times do you typically eat a serving of fruit in **one day** (For example, an apple, an orange, raisins, fruit juice, a hand full of grapes, etc.)?  
a. 0; 1; 2; 3; 4; 5; 6; 7; more than 7
120. How do you feel about how much fruit you eat in one day?  
a. I do not plan to start eating more or less fruit.  
b. I plan to start eating more fruit in the next 6 months.  
c. I plan to start eating more fruit in the next month.  
d. I have been trying to eat more fruit recently (within 6 months).  
e. I have been trying to eat more fruit for more than 6 months.  
f. I plan to start eating less fruit.
121. Overall, when you think about the foods you ate over the past 12 months, would you say your diet was high, medium, or low in fat (e.g. butter, cook with oil, etc.)?  
a. High  
b. Medium  
c. Low
122. How do you feel about how much fat you eat?  
a. I do not plan on trying to eat more or less fat  
b. I plan to try to eat less fat in the next 6 months.  
c. I plan to start eating less fat in the next month.  
d. I have been trying to eat less fat recently (within 6 months).  
e. I have been trying to eat less fat for over 6 months.  
f. I plan to start eating more fat.  
g. I don't know what the fat content of my diet is.
123. Do you know what your current **TOTAL Blood Cholesterol** is?  
a. Yes, it is about \_\_\_\_\_ mg/dl  
b. No
124. Do you think your **Total Cholesterol** is:  
a. Good  
b. Not good  
c. I am unsure or don't know.
125. Do you currently take Cholesterol –Lowering Medication?  
a. Yes\_\_\_\_\_



- i. If Yes: About how long have you been taking that medication? \_\_\_\_\_ Years
- b. No \_\_\_\_\_
126. Do you know what your Body Mass Index (BMI) is?
- a. Yes, it is about \_\_\_\_\_ kg/m<sup>2</sup>
- b. No
127. Do you believe you are:
- a. Underweight
- b. Normal Weight
- c. Overweight
- d. Obese
- e. I am not sure or don't know
128. Throughout the duration of this study, have you received any education (your doctor, the internet, magazines etc) in:
- a. Weight management Yes \_\_\_\_\_ No \_\_\_\_\_
- b. Diet/ Nutrition Yes \_\_\_\_\_ No \_\_\_\_\_
- c. Physical Fitness Yes \_\_\_\_\_ No \_\_\_\_\_
129. Regular physical exercise is defined as being active on 3 or more days a week. **Do you participate in regular physical exercise?**
- a. I don't and I am not thinking about starting in the near future.
- b. I don't but I plan to start in the near future.
- c. I don't but I do at least some physical exercise once or twice per week.
- d. I do and have done so for less than 6 months.
- e. I do and have done so for longer than 6 months.
130. Which statement best describes how you feel about your **weight**:
- a. My weight is about right and I am not planning on trying to change it.
- b. I want to lose weight, but I don't know where to start.
- c. I have decided to lose weight and I have a plan to start in the next 6 months.
- d. I plan on starting to make changes (diet, exercise etc) within the next month.
- e. I have recently made changes to lose weight (within 6 months).
- f. I have been making changes to lose weight for longer than 6 months.
- g. I am trying to gain weight.

Please place a checkmark in the box corresponding with how you feel about each of the following statements.

		Almost always	Some of the time	Hardly ever
131.	I am satisfied that I can turn to a fellow worker for help if something is troubling me.			

132.	I am satisfied that my fellow workers accept and support my new ideas and thoughts.			
133.	I am satisfied with how well I get along with my closest or immediate supervisor.			

### Modified Zung Depression Index

Please indicate for each of the following questions which answer best describes how you have been feeling recently.				
	Rarely or none of the time (less than 1 day per week)	Some or little of the time (1–2 days per week)	A moderate amount of time (3–4 times per week)	Most of the time (5–7 days per week)
134. I feel that nobody cares				

135. Altogether, about how much time do you spend **sitting while at work**?

- ☐ ½ hour   
 ☐ 1 hour   
 ☐ 1½ hours   
 ☐ 2 hours   
 ☐ 2½ hours   
 ☐ 3 hours  
☐ 3½ hours   
 ☐ 4 hours   
 ☐ 4½ hours   
 ☐ 5 hours   
 ☐ 5½ hours   
 ☐ 6 hours  
☐ 6½ hours   
 ☐ 7 hours   
 ☐ 7½ hours   
 ☐ 8 hours   
 ☐ 8½ hours   
 ☐ 9 hours  
☐ 9½ hours   
 ☐ 10 hours   
 ☐ 10½ hours   
☐ 11 hours   
 ☐ 11½ hours   
☐ 12 hours

136. Do you have high foot arches? Yes / No / Unsure

137. Do you have flat feet? Yes / No / Unsure

The following statements ask you to think about physical pain you have or have had and how it relates to God and religion. Please consider your answers to these questions regardless of whether or not you have received any type of medical treatment.

138. On average, how often do you attend religious services?
- More than once a week
  - Once a week

- c) 2-3 times a month
- d) Once a month
- e) Every other month
- f) 1-3 times a year
- g) Never
- h) Don't know
- i) Decline to answer

139. On average, how often do you communicate with God? (Prayer at bedtime, meals, family time, etc):

- a) More than once a day
- b) Daily
- c) 2-3 times a week
- d) 2-3 times a month
- e) Less than once a month
- f) Never
- g) Don't know
- h) Decline to answer

140. Generally, when thinking about your physical pain, which of the following statements describes how you *most often* think about physical pain in relation to God;

- a) Wondered if it was a punishment from God
- b) Thought that God might be trying to strengthen me
- c) Neither

141. Generally, when thinking about your physical pain, which of the following statements describes how you *most often* try to alleviate physical pain in relation to God;

- a. Only pray for relief
- b. Make a bargain with God to relieve my pain
- c. Make a plan with God to relieve my pain
- d. None of the above

142. Generally, when thinking about your physical pain, which of the following statements describes how you *most often* try to alleviate physical pain in regards to religious members and/or leaders;

- a. Look to religious members and/or leaders for spiritual support (e.g. prayers of healing)
- b. Look to religious members and/or leaders for social support (e.g. bring you food or medicine, give advice on treatment or doctors, etc.)
- c. Neither

143. I try hard to live all my life according to religious beliefs.

0 (I never live my life according to religious beliefs)

1

2

3  
4  
5  
6  
7  
8  
9

10 (I always live my life according to religious beliefs)

144. Other things in life are more important than religion and/or God.

0 (Nothing else is more important than religion and/or God)

1  
2  
3  
4  
5  
6  
7  
8  
9

10 (Everything is more important than religion and/or God)

145. What is your religious affiliation?

- ☐ Agnostic
- ☐ Atheist
- ☐ Buddhist
- ☐ Catholic
- ☐ Church of Jesus Christ of Latter Day Saints
- ☐ Hindu
- ☐ Islamic
- ☐ Jewish
- ☐ Non-denominational (e.g. Church of Christ, Assembly of God, etc.)
- ☐ Orthodox
- ☐ Protestant (e.g. Presbyterian, Methodist, Baptist, etc.)
- ☐ Unaffiliated
- ☐ Other, (please specify) \_\_\_\_\_
- ☐ Decline to answer

***Thank you for completing the questionnaire.***